Non-Commercial Business Impact . . . Executive Summary

Increased Managed Care Enrollment

- Volume shift from traditional indemnity / FFS to managed care
- Emergence of less restrictive managed care products, i.e., POS, PPO, to compete with traditional Indemnity / FFS plans

Steep Provider Discounts

- Managed care plans sought cost saving opportunities through provider discounts and selective contracting
- Can be responsible for up to 20% negative impact on non-HMO commercial payment to providers

Excess Bed Capacity

- Hospital providers lacked negotiation leverage due to excess bed capacity

Declining Inpatient Utilization Trends

- A declining hospital utilization trend did not improve hospital occupancy over time
- Can be responsible for up to 14% negative impact on non-HMO commercial payment to providers

Source: Robert Wood Johnson Foundation; Center for Health Care Policy and Evaluation

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Research studies show that managed care product price discounting can be responsible for non-managed care product pricing discounts of up to 20%.

Price Discount Impact Studies

Research Study / Source	Key Finding
Johns, L. "Selective Contracting in California." *Health Affairs,* Fall 1985	• In the California MediCal program, selective contracting with hospitals was found to be responsible for cost reduction of over 15%
Verrilli, D.K., Zuckerman, S. "Preferred Provider Organization and Physician Fees." *Health Care Financial Review,* Spring 1996161-170	• Two national PPOs negotiated a weighted average price discounts of 12 – 21% for physician services compared to traditional insurance in 1993
Lewin Group (1994, 1997)	• PPOs and POS achieved an 8% savings from provider discounts and utilization management from 1991 to 1996 • The estimate is lower than other studies, in part, because they take account of the additional plan administrative costs involved in obtaining and processing discounts
American Association of Preferred Provider Organization (1999)	• PPOs offer savings over traditional health plans. The source of cost savings is primarily discounts on physician fees and hospital per diem payments, with discounts ranging up to 20% off standard fees

Source: Health Affairs, Health Care Financial Review, Lewin Group, American Association of Preferred Provider Organizations; BDC Advisors, LLC

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The implementation of utilization management programs to improve the financial performance of managed care products has reduced non-HMO product provider payments by up to 14% from decreased non-HMO patient utilization.

Utilization Impact Studies

Research Study / Source	Key Finding
Smith, D. "The Effects of Preferred Provider Organization on Health Care Use and Costs." Final Report to the Robert Wood Johnson Foundation, Grant No. 20040. Ann Arbor, MI: University of Michigan, November 1995	• PPOs showed costs savings of 12 to 14% when compared to indemnity plan with utilization review[1] • This cost saving was the result of lower utilization rates, including 9.7% lower rate of physician office visits and 9.3% lower rate of hospital admissions
The Lewin Group, "Managed Care Savings", 1997, commissioned by American Association of Health Plans	• Each ten percentage point increase in managed care enrollment is associated with a one percentage point reduction in the rate of growth in health spending for all plans, including traditional indemnity plans
Frech, T., "Managed Health Care Effects: Medical Care Costs and Access to Health Insurance", Department of Economics, University of California, Santa Barbara, 2000	• The practice of utilization management by managed care health plans decreased utilization and is responsible for up to 8% in cost savings for PPO and POS, and up to 22% in cost savings for HMOs
Greenfield S, et al. "Variations in Resource Utilization Among Medical Specialties and Systems of Care. *Journal of the American Medical Association*. March 25, 1992	• After adjusting for differences in patient mix, traditional practice / payment methods had 41% more hospitalization and 12% higher prescription drug use than HMOs
Miller RH, Luft HS. Managed Care Plan Performance Since 1980: A Literature Analysis. *Journal of the American Medical Association*. May 18, 1994	• A review of research since 1980 found lower hospital use in HMOs (reflecting both generally lower admission rates and consistently shorter length-of-stay), reduced intensity of tests and procedures, and mixed effects on physician visits, compared to traditional coverage

Source: Robert Wood Johnson Foundation, Lewin Group, Journal of the American Medical Association, UCSB, American Association of Health Plans; BDC Advisors, LLC

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IDS Strategy and AHERF Application

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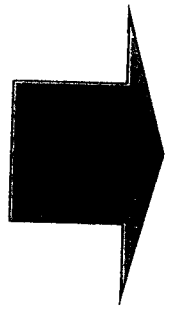
Growth in managed care and reductions in payment among selected payors and volume created new challenges for hospital systems. A common response among Delaware Valley hospital systems was the formation of integrated delivery systems (IDS).

Strategic Objective

- Increase scope of service
- Control managed care lives
  - ➔ Grow volume to stabilize revenue
  - ➔ Additional patients to support research and teaching mission
- Acquire physician practices
  - ➔ Increase patient base through broader geographic coverage
  - ➔ Primary care physicians to manage service delivery and control total cost
- Consolidate hospital capacity
  - ➔ Broader geographic coverage
  - ➔ Control costs
- Infrastructure investments
  - ➔ Develop care management systems required under managed care contracts



IDS Imperative

- Establish relationship with a medical school to gain access to state-of-the-art science and medicine
- Grow regional share to improve negotiations with health plans
- Develop primary care physician (PCP) networks to increase patient base and appeal to health plans for the management of covered lives
- Develop relationship with community hospitals to increase patient base
- Improve operational effectiveness to achieve cost competitiveness and enhance clinical quality

Source: AHERF Strategic Planning and acquisition material; BDC Advisors, LLC analysis

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